

South Carolina Workers' Compensation Commission

1612 Marion Street
Post Office Box 1715
Columbia, South Carolina 29202-1715
803-737-5723



WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ SSN: _____ - - Employer's Name: _____
Address: _____ Address: _____
City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____
Home Phone: () - Work Phone: () - Insurance Carrier: _____
Preparer's Name: _____ Law Firm: _____ Preparer's Phone #: () -

Date Attorney Was Hired: _____ Date of Injury: _____
Compensation Rate: _____ Does this conclude the case? ☐ Yes ☐ No

PLEASE CHECK AND COMPLETE ONLY ONE: (A, B or C)

☐ **A.** R.67-1205C does not apply to the facts of this case. A _____ % fee of the award or settlement (excluding medical costs) and the costs of this action, as shown by the attached Settlement of Costs, are requested for approval.

☐ **B.** The subsection of R. 67-1205C applicable to this claim is (C) () . A fee of \$ _____ is requested for approval based on the following:

Date of first impairment rating or offer of settlement: _____

Impairment Rating given and/or **Settlement amount** offered prior to date attorney hired: _____

Impairment Rating given and/or **Settlement amount** offered after date attorney hired: _____

Authorized Health Care Provider's Name: _____

☐ **C.** Admitted Death Claim - \$2,500.

I agree to pay my attorney the fee and costs stated. I understand the fee and costs are paid out of my compensation and I understand how much money I will receive after I pay my attorney.

Client

Date

I certify that this form and the attached Statement of Costs are accurate.

Attorney for Claimant

Date

Summary	
Total Amount of Compensation	\$ _____
Attorney's Fee	\$ _____
Costs	\$ _____
Total Fees and Costs	- \$ _____
Client Will Receive	\$ _____

RESERVED FOR COMMISSION'S USE:

☐ Approved ☐ Rejected ☐ Set for Hearing

Commissioner

Date

A Statement of Costs must be attached before costs may be approved. File this form in duplicate with the Claims Department. Enclose a self-addressed, stamped envelope. For further information, refer to R.67-1203, R.67-1204, R.67-1205, and R.67-1206.